

75 CLAREMONT ST #G
 KALISPELL, MT 59901
PHONE: (406) 752-8161
FAX: (406) 752-8090



TODAY'S DATE:

PATIENT INFORMATION

Last Name:	First Name:	Nickname:	MI:
Street Address:	Patient Gender:		
City: State: Zip:	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		
Mailing Address (if different from above):	If Married, Spouse's Name:		
City: State: Zip:	Patient Birth Date (Month/Day/Year):		
Home Phone:	Patient Social Security Number:		
Cell Phone:	Email Address:		
Work Phone:	Best contact (Circle one): Home PH Cell PH Text Email		
Employer/Position:	Work PH		

RESPONSIBLE PARTY INFORMATION

(complete if different than patient information above)

Contact Name:	Relationship:
Social Security Number:	Date of Birth (Month/Day/Year):
Address:	Home Phone:
City: State: Zip:	Cell Phone:
Employer:	Work Phone:

DENTAL INSURANCE INFORMATION

Primary Insured Name:	Secondary Insured Name:
Home Address (if not listed above):	Home Address (if not listed above):
Primary Insured SSN:	Secondary Insured SSN:
Primary Insured Date of Birth (M/D/Y):	Secondary Insured Date of Birth (M/D/Y):
Primary Insured Employer:	Secondary Insured Employer:
Dental Insurance Company: Dental Claim Address:	Dental Insurance Company: Dental Claim Address:
Subscriber Number: Group Number:	Subscriber Number: Group Number:

EMERGENCY CONTACT NAME: _____ PHONE: _____ RELATIONSHIP: _____	Where did you hear about our office: Did you see us online: <input type="checkbox"/> Yes <input type="checkbox"/> No Which application: <input type="checkbox"/> Google <input type="checkbox"/> Google Map <input type="checkbox"/> YELP <input type="checkbox"/> Other: _____
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PATIENT MEDICAL HISTORY

Please circle applicable answer. Your answers are for our records only and will be considered CONFIDENTIAL

Approximate date of your last dental exam: _____

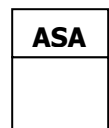
- | | | |
|---|--|----|
| 1. Are you in good health? | Yes | No |
| Has there been any change in your health in the past year? | Yes | No |
| 2. Name of your physician: _____ | Approximate date of your last physical exam: _____ | |
| 3. Is a physician currently treating you? If so, why? _____ | Yes | No |
| 4. Have you been hospitalized or had a serious illness within the last five (5) years?
Description: _____ | Yes | No |
| 5. Do you take any pills, drugs, or medicines?
If so, what? _____ | Yes | No |
| 6. Are there any medications that you are allergic to or cannot take?
(such as aspirin, penicillin, morphine, Valium) If so, what? _____ | Yes | No |
| 7. Have you experienced an unusual reaction to local anesthetic (e.g. novacaine)? | Yes | No |
| 8. Are you allergic to latex? | Yes | No |
| 9. Have you ever had any of the following? (Please check if applicable) | | |

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Adenoids removed | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pain in jaw joints (TMJ) |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Diagnosis _____ |
| <input type="checkbox"/> Asthma / Breathing Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Prior orthodontic treatment |
| <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Injury to teeth | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Jaw Surgery | <input type="checkbox"/> Recent weight loss |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chronic sinus problems | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Heart pounding or beating
irregularly during the night | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Convulsions / Seizures | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Morning dry mouth | <input type="checkbox"/> Venereal Disease / HPV |
| <input type="checkbox"/> Difficulty concentrating | | <input type="checkbox"/> Nighttime sweating | <input type="checkbox"/> Wisdom teeth extraction |

Have you ever had any serious disease/ medical condition not mentioned above? _____ Describe: _____

- | | | |
|--|-----|----|
| 10. Do you have an artificial heart valve, hip prosthesis or other implant? | Yes | No |
| 11. Cardiovascular: | | |
| Do you have chest pain on mild exertion? | Yes | No |
| Are you short of breath after mild exertion? | Yes | No |
| Do your ankles swell? | Yes | No |
| Do you get short of breath when you lie down or do you require extra pillows when you sleep? | Yes | No |
| 12. Does your mouth frequently become dry? | Yes | No |
| Is there history of diabetes in your family? | Yes | No |
| Do you have to urinate frequently? | Yes | No |
| 13. Do you smoke? | Yes | No |
| Do you chew smokeless tobacco? | Yes | No |
| 14. Does it make you anxious/nervous to visit the dentist | Yes | No |
| 15. Have you had any problems associated with previous dental treatment?
If yes, please explain _____ | Yes | No |
| 16. Do you think that your teeth are affecting your general health in any way? | Yes | No |
| 17. If female, please circle if you are 1) pregnant 2) nursing 3) taking birth control pills | | |

Chief Dental complaint: _____



FINANCIAL POLICIES

1. Payment is expected in full at the time of service unless a financial payment plan has been agreed upon in advance of treatment. We accept all major credit cards, cash, personal checks and Care Credit.
2. We are not a preferred provider or an in-Network dentist for any insurance carrier.
3. For patients with dental insurance, we are happy to work with your carrier to maximize your benefit. The charges submitted to the insurance carrier will become due and payable 90 days from the date of filing if no response or payment is received. If the insurance company denies coverage, payment is due immediately. If secondary insurance is carried, we will file the secondary claim once payment is received from the primary insurance. Explanation of Benefits (EOB) copies are required to submit the secondary claim. If a payment of dental benefits is made to you directly and a secondary insurance is involved, you will need to supply our office with a copy of the EOB so that the secondary claim can be submitted for you.
4. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company; therefore we do not confirm insurance eligibility for recommended treatment. Any insurance information given to you by this office is *strictly an estimate* of benefits and *not a guarantee of payment*. Insurance benefit payments are determined solely by your insurance company and are subject to review of the claim, eligibility status and terms and conditions of your specific policy. This office is not responsible for monitoring patient's insurance policy limitations, waiting periods and plan maximums.
5. All co-payment and deductible amounts are due and payable at the time service is rendered in accordance with the legal requirements prohibiting writing off of patient responsibility amounts. Insurance payments made directly to the patient for services provided by our office and due and payable to us once received by the patient.
6. We do not accept Medicaid.
7. The responsibility for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.
8. Our office charges \$25 for returned checks.
9. Balances that are 60 days past due are subject to a 1.5% monthly service charge, which is an APR of 18%.
10. If your account is sent to collections, you will be responsible for any and all collection fees, court costs and/or attorney fees.

Initial: _____

CANCELLATION POLICY

Our staff is prepared to offer each patient the individual attention necessary to understand and treat your dental needs. To ensure you receive this attention, we set aside dedicated time for each appointment. If you find it necessary to cancel an appointment, we request that you give our office at least 24 hours notice. If appropriate notice is not given, you may be charged \$50 for a broken or cancelled appointment.

All cancellation fees must be paid prior to scheduling another appointment.

INFORMED CONSENT FOR DENTAL TREATMENT

I understand there are rare complications and/or side effects to any dental treatment that I might receive. There may be: 1) pain, swelling, inflammation or infection of the area of the injection of local anesthesia, 2) injury to nerves or blood vessels in the area, 3) an allergic or unexpected reaction to materials and/or medications.

Fortunately, these complications and side effects are not common. Most dental treatment is generally very safe, comfortable and well tolerated.

I have given complete and truthful medical history, listing all medications, drug use, pregnancy, etc.

I grant the right to the dentist to release my dental histories and other needed information about my dental treatment to third party payers and/or health professionals.

I certify that I speak, read and write the English language.

I have received and reviewed a copy of the privacy practice notice (HIPPA).

I have read and understand the above risks and give my consent for dental treatment.

I ACKNOWLEDGE I HAVE READ AND AGREE TO ABIDE BY THE FINANCIAL POLICIES & THOSE DESCRIBED ABOVE.

PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE: _____ **DATE:** _____

REPRESENTATIVE FOR DR. LESLIE B. ANTHONY DMD, PC: _____ **DATE:** _____

